DELINEATION OF CLINICAL PRIVILEGES - ORTHOPAEDICS

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform 2 - Modification requested *(Justification attached)* 3 - Supervision requested 4 - Not requested due to lack of expertise 5 - Not requested due to lack of facility support	1 - Approved as fully competent 2 - Modification required *(Justification noted)* 3 - Supervision required 4 - Not approved, insufficient expertise 5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

Requested	Approved		Requested	Approved	
		a. Amputation, major			r. Osteotomy
		b. Arthrocentesis			s. Osteomyelitis and septic arthritis, drainage of
		c. Arthroscopy, diagnostic and surgical			t. Prosthetic replacement of bones and joints
		d. Arthrodesis			u. Release and/or excision of muscles, tendons, fascia, ligaments and nerves
		e. Arthroplasty			v. Reimplantation of severed digits using microvascular technique
		f. Arthrotomy			w. Scoliosis and kyphosis, surgical correction with or without posterior instrumentation
		g. Bone graft procedures			x. Scoliosis and lordosis, surgical correction with or without anterior instrumentation
		h. Bone and muscle transposition to restore function or form of extremities			y. Skeletal defects:
		i. Excision of:			(1) Intercalary reconstruction of segmental defects
		(1) Bursae, calcium deposits, soft tissue tumors of extretity			(2) Reconstruction using synthetic or metal materials
		(2) Herniated nucleus pulposus			z. Tendon grafts with or without preliminary silastic tendon prosthesis
		(3) Degenerated intervertebral disc			aa. Tendon repair, transfer, lengthening or shortening
		(4) Bone tumors			ab. Ligament repair and reconstruction - hand, knee, ankles, shoulders, and elbows
		j. Flaps, local and distant microvascular free			ac. Nerve:
		k. Fractures and dislocations, open and closed reduction of major injuries, including skeletal traction			(1) Transplantation
		l. Fusion of spine:			(2) Grafts
		(1) Anterior, posterior cervical			(3) Repair
		(2) Anterior, posterior thoracic			ad. Use of cement, i.e., methyl methacrylate, with or without prosthetic use
		(3) Anterior, posterior lumbar			ae. Anesthesia, low and regional blocks
		m. Grafts, split thickness skin			af. Chemonucleolysis
		n. Grafts, full thickness and pedicle			ag. Lumbar puncture
		o. Hip nailing			ah. Myelography
		p. Laminectomy			
		(1) Cervical			
		(2) Thoracic			
		(3) Lumbar			
		q. Manipulation of deformities of musculo-skeletal system			

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*

EVALUATION OF CLINICAL PRIVILEGES - ORTHOPAEDICS

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	PRIVILEGES	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. Amputation, major			
	b. Arthrocentesis			
	c. Arthroscopy, diagnostic and surgical			
	d. Arthrodesis			
	e. Arthroplasty			
	f. Arthrotomy			
	g. Bone graft procedures			
	h. Bone and muscle transposition to restore function or form of extremities			
	i. Excision of:			
	(1) Bursae, calcium deposits, soft tissue tumors of extretity			
	(2) Herniated nucleus pulposus			
	(3) Degenerated intervertebral disc			
	(4) Bone tumors			
	j. Flaps, local and distant microvascular free			
	k. Fractures and dislocations, open and closed reduction of major injuries, including skeletal traction			
	l. Fusion of spine:			
	(1) Anterior, posterior cervical			
	(2) Anterior, posterior thoracic			
	(3) Anterior, posterior lumbar			
	m. Grafts, split thickness skin			
	n. Grafts, full thickness and pedicle			
	o. Hip nailing			
	p. Laminectomy			
	(1) Cervical			
	(2) Thoracic			
	(3) Lumbar			
	q. Manipulation of deformities of musculo-skeletal system			
	r. Osteotomy			
	s. Osteomyelitis and septic arthritis, drainage of			
	t. Prosthetic replacement of bones and joints			
	u. Release and/or excision of muscles, tendons, fascia, ligaments and nerves			
	v. Reimplantation of severed digits using microvascular technique			
	w. Scoliosis and kyphosis, surgical correction with or without posterior instrumentation			
	x. Scoliosis and lordosis, surgical correction with or without anterior instrumentation			

CODE	PRIVILEGES	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	y. Skeletal defects:			
	(1) Intercalary reconstruction of segmental defects			
	(2) Reconstruction using synthetic or metal materials			
	z. Tendon grafts with or without preliminary silastic tendon prosthesis			
	aa. Tendon repair, transfer, lengthening or shortening			
	ab. Ligament repair and reconstruction - hand, knee, ankles, shoulders, and elbows			
	ac. Nerve:			
	(1) Transplantation			
	(2) Grafts			
	(3) Repair			
	ad. Use of cement, i.e., methyl methacrylate, with or without prosthetic use			
	ae. Anesthesia, low and regional blocks			
	af. Chemonucleolysis			
	ag. Lumbar puncture			
	ah. Myelography			

SECTION II - COMMENTS *(Explain any rating that is "Unacceptable".)*

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*